

Compartmentalization of total and virus-specific tissue-resident memory CD8⁺ T Cells in human lymphoid organs

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“Being brave”

A case study of how an innovative peer review approach led to service improvement

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Abstract

Purpose – The purpose of this paper is to report on the use of an innovative peer review approach to identifying and addressing the causes of inappropriate admissions from hospital to nursing homes in South Gloucestershire (SG). It explains the methodology that was developed, the findings of the peer review process and reflects on the effectiveness of the process.

Design/methodology/approach – The peer review consisted of two stages. The first stage involved a panel of local stakeholders carrying out an audit of a random selection of cases where people had been assessed as needing permanent nursing or residential care. From this four cases of inappropriate admissions were identified. Stage two involved an externally facilitated process with two peer challenge panels; one of local stakeholders and the other external experts. The two panels analysed the cases of inappropriate admissions, identified the system causes and suggested actions to tackle the issues which were fed back to an audience of local stakeholders.

Findings – The combination of case audit and peer review was successful in providing robust challenge to the processes in SG by identifying shortcomings in the system and suggesting actions to improve outcomes.

Research limitations/implications – The approach was taken in one Council area and therefore may not be replicable in another area.

Practical implications – The case study suggests that a peer review approach using both local and external peers, including providers, is an effective way to identify weaknesses in the health and social care processes. The insights offered by external peers and providers is helpful for councils in identifying where to focus resources and suggests that other areas should consider proactive adaptations to the peer review methodology that is offered as part of the LGA's programme of sector-led improvement.

Social implications – The case study suggests that a peer review approach could have a positive impact on the quality of care and quality of life for older people who are admitted to hospital.

Originality/value – The case study offers an innovative and original use of the peer review approach in social care that can be shared with other councils and partners. The Southwest Improvement Board have identified it as of particular interest to other areas seeking to work with partners to identify and implement positive change.

Keywords Partnership working, Health and social care, Interagency working, Peer review, Peer challenge, Case audit

Paper type Case study

Introduction

Peer challenge is a central plank of England and Wales' local government's sector-led improvement approach to performance assessment. The English local government membership body the Local Government Association (LGA) states that “We know that challenge from one's peers is a proven tool for improvement” (Local Government



Q2

Association (LGA, 2011, p. 6). However there is little in the academic literature about the effectiveness of peer challenge in supporting organisations to improve. Although there is some evidence to suggest that peer challenge may offer businesses some collaborative advantage, (Hansen and Nohria, 2004), Martin *et al.* (2013) suggest in their commentary on the performance framework for public services that there is little empirical evidence about the impact of any form of performance assessment on public services. This is the case for both the top down, external assessment and the performance indicator approach of the Labour Government, and the more recent regime of sector-led support that has replaced it. Nevertheless, peer challenge has been widely welcomed by the local government sector in both England and Wales as having “a positive impact on their capacity to take responsibility for their own improvement” (Cardiff Business School, 2014, p. 3). It has also been argued that peer challenge should form part of a “whole systems approach that links up all of the different elements of a performance framework including self-assessments, peer challenge, statutory reporting and external inspections” (Martin *et al.*, 2013, p. 279).

The terms peer challenge and peer review are used interchangeably in the literature, although the term peer review tends to be used at a regional level when describing the peer element of Adult Social Care improvement. In this paper peer challenge is used to describe the national approach, with peer review used when discussing the regional social care peer process.

The emergence of sector-led improvement

Q3

Sector-led improvement as a performance management approach emerged as a result of the abolition of the Labour Government’s performance framework. This abolished the Audit Commission, which audited Council performance in England and Wales, and with it comprehensive area assessment, the organisational assessment, Local Area Agreements and Government Office monitoring, and the annual assessment of adult social services. The Coalition Government argued that greater weight should instead be placed on local accountability, in tune with its localism agenda. The LGA’s new approach to sector-led improvement was set out in its document “Taking the Lead” in February 2011, (LGA, 2011) which was supplemented in June 2012 by “Sector-led improvement in local government” (LGA, 2012a). This describes a coordinated approach to sector-led improvement across local government and the support for councils that will be provided.

Sector-led improvement is based on the underlying principles that local authorities are:

- responsible for their own performance and improvement;
- accountable locally to the communities they serve, not nationally; and
- there is a sense of collective responsibility for the performance of the sector as a whole.

This approach to improvement has been adopted in both England and Wales (where it is supported by the Welsh LGA). Other systems of improvement are in place in other parts of the UK, which have retained a regime of audited performance indicators, although the lessons from sector-led improvement are applicable across whole of local government in the UK. The shift towards sector-led and self-improving systems has not been limited to local authority services. Davies *et al.* (2000) suggest that across a wide range of professions there has been an ambition to promote devolved responsibility for

improvement, increased local accountability and empowerment of the professional fields operating across different sectors. Davies *et al.* suggest that the intention to drive forward a sector-led improvement agenda is clear across a range of professional spheres: In Adult Social Care, the Department of Health's (DH) Vision for Adult Social Care: Capable Communities and Active Citizens, sets out how the government wishes to see services delivered. Two of the seven principles focus on greater local accountability to drive improvements and innovation; and a workforce who can "provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so" (DH, 2010, p. 8).

Peer challenge as a tool for improvement in social care

The LGA define peer challenge a "a process commissioned by a Council (which involves engaging with a wide range of people connected with the Council and bringing to bear highly experienced peers in the relevant services areas, with the findings delivered immediately" (Local Government Association (LGA), 2014, 2015, p. 5). As part of its sector-led improvement offer, the LGA has offered each Council a free corporate peer challenge offer and has developed a standard methodology for the approach.

The peer challenge "offer" now includes a wide range of services including corporate peer challenge, health and well-being peer reviews, housing peer reviews and fire peer reviews.

In terms of Adult Social Care performance, until 2010 councils were assessed annually on their Adult Social Care performance by the Care Quality Commission (CQC), but this was ceased in order, according to the former head of the CQC, to bring the monitoring of Council performance closer to local people (Shared Intelligence, 2015). The sector-led improvement approach for Adult Social Care is led through the Towards Excellence in Adult Social Care (TEASC) programme and through this, peer challenge has come to play a role in sector-led improvement of the Adult Social Care sector. TEASC is a partnership board for Adult Social Care services and includes representatives from the Association of Directors of Adult Social Services, the LGA, the CQC, the DH, Social Care Institute for Excellence, Society of Local Authority Chief Executives and the Think Local Act Personal Partnership.

Peer challenge for Adult Social Care services is described by the LGA as "a constructive, learning opportunity" which aims to help local government to help itself to respond to the changing agenda for Adult Social Care (LGA, 2015, p. 3). The peer review process is supposed to offer practitioner perspective and critical friend challenge (LGA evaluation of SLA peer challenge). Councils have reported that the feedback and reports from corporate peer challenge teams offered challenging, constructive and honest insight. They also appreciated the way in which it can be tailor made for the local situation.

In 2012, a survey of Directors of Adult Social Care found that 15 per cent would not consider taking part in a peer challenge. However, the evaluation of peer challenge in Adult Social Care (2015) found that "the principle of sector-led improvement, and the central contribution to that of peer review, has been widely adopted by the sector" (Shared Intelligence, 2015). The programme for peer challenge is funded and organised at a regional level, with most regions suggesting that every authority should have a peer review over an agreed timescale, providing reviews of performance data and some reviewing the learning from peer reviews carried out in their area.

The evaluation reported a high level of confidence in the peer challenge process amongst social care senior managers. One reason for this is the "power of peers".

The report states that “The people we spoke to talked about the importance of the director to director conversations that take place as part of a peer review”. People in areas which have developed a regional peer review model are confident that the act of exposing a service to peers with whom there will be continued contact is more challenging than doing so to an inspector who may never be seen again (Shared Intelligence, 2015, p. 16). The report concludes that this regional approach has more value than the standard LGA model, which draws on a national pool of peers, because the regional dimension is seen as enabling relationships.

Being brave

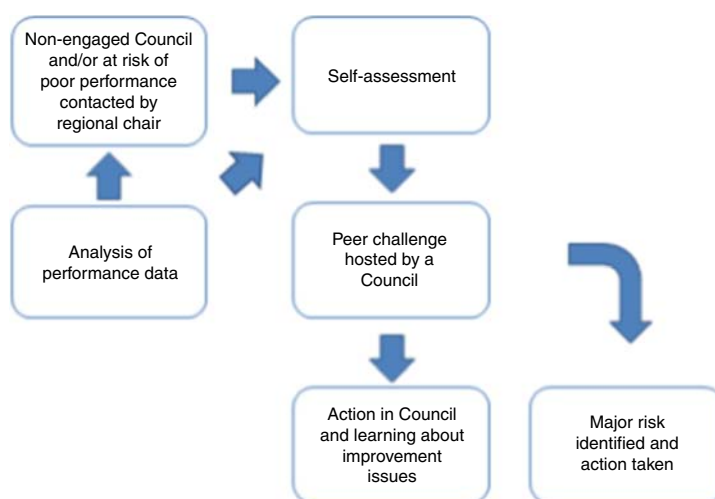
The evaluation report draws on the evidence of peer challenges within social care to suggest a “logic model” of how peer challenge leads to improved performance and reduction in risk (Figure 1).

An early evaluation report (LGA, 2015) summarised the findings from the first seven peer challenges in Adult Social Care. These highlighted some consistent themes for improvement:

- partnerships and coproduction – ensuring that councils work in partnership with stakeholders, providers and communities to support personalisation of social care services and a focus on outcomes for individuals;
- developing systems to support change and improvement – through performance management processes including file audits, and self-assessments; and
- member and provider development – ensure there are effective working relationships between lead members and officers and that members are supported to develop their role in overview and scrutiny.

Standard peer review approach

The LGA has offered a standard approach to a social care peer review. This involves the LGA putting together a team of peers based on the needs of the client, who have a knowledge of the Adult Social Care sector, from having worked in it, from having



Source: Shared Intelligence (2015)

Figure 1.
A logic model illustrating how peer challenge leads to improved performance and reduction in risk

used its services or from working with it as a partner organisation. Peer review teams can also include colleagues from across public health, the police, probation and other organisations and sectors, bringing a wide range of perspectives to the key lines of enquiry (Shared Intelligence, 2015). The team spends up to five days on site reviewing an authority's Adult Social Care Department, or certain aspects of the service. As part of the review, the team speak to a range of individuals including frontline and strategic staff in Adult Social Care, service user groups and partner agencies. The scope of each review is decided by the authority in discussion with the LGA. Each review includes an assessment of current achievements and provides recommendations of how further improvements can be made. At the end of the period on site, the review team offer initial feedback. The exact form this takes varies, but it usually involves the review lead offering verbal feedback, which is then followed up by the report.

Despite this standard offer, the evaluation report notes that the peer challenge process has evolved at a regional and local level. It is one such evolved approach that this paper will now focus on.

The SG context

SG is a unitary Council set between Bristol to the south and Gloucestershire to the north, with Wiltshire to the east. It has a population of around 263,000 (2011 census) (SG JSNA, 2011). The demographics of the area are broadly consistent with the national average, although the population of people aged 65 and over is increasing at a higher rate than regionally or nationally. A priority for the Council and its partners is to promote independence and personalisation in adult care services, with a central principle that people should be supported to live in their own homes for as long as possible.

The aim of the peer review

Analysis of the national data set of Adult Social Care outcomes (ASCOF 2A) showed that SG was in the bottom quartile in terms of performance in permanent admissions to residential and nursing care per 100,000 population up to 2014. Further analysis of the local data showed that the low ranking was most strongly influenced by the activity leading to placing new people into nursing home placements. In the context of the 65 and over population increasing at a higher rate than regionally or nationally this was leading to high numbers of permanent admissions to nursing homes (South Gloucestershire Council, 2011).

In order to understand what was driving the high numbers of admissions, the Head of Adult Social Care and Director of Public Health wanted to commission a process to:

- build an understanding of the way decisions are made to permanently admit people to nursing homes; and
- using the conclusions and recommendations to agree steps to improve decision making and to improve the experiences and outcomes for people and their families.

They judged that a combination of a review of case files and a peer review approach involving both local partners and regional LGA peers would enable them to understand what was driving decisions and how to improve those processes.

Methodology

SG designed a bespoke, unique methodology which combined case audit and peer review, which enabled them to gather and analyse the most useful and meaningful data

and views. The original approach was designed by the Director of Public Health and the Head of Adult Social Care (HASC) to introduce an evidence-driven public health approach to a traditionally Adult Social Care operational service area. It was recognised by the HASC that the review needed to be robust to ensure credibility with the LGA and wider audience, especially allied professionals.

There were two stages to the approach.

Stage 1 – the case audit

This case audit was designed to enable an in depth discussion by a wide range of care professionals about a small representative sample of cases where people had been admitted to nursing homes to consider whether appropriate decisions are being made. The decision was taken to involve local partners in the initial case audit, in order to offer robust local insight and challenge. The findings from this audit would feed into the wider peer review process.

The SG process of approval to admitting someone into a nursing home is through a weekly panel, chaired by the SGC HASC. The hospital process allows the service manager to approve placements outside of this panel process.

For the case audit, ten case files of SG residents newly admitted on a permanent basis to a nursing home were selected at random from all of the admissions during the period 1 April 2014-30 June 2014. The case files were selected to ensure that the admissions from the community (4) and from hospital (6) were in proportion to the background rate of admission and were reviewed by the HASC to ensure that any unusual cases could be removed. In the event no unusual cases were identified. A decision tree was used to identify only those placements that were new, Council funded, referral from hospital to nursing home or community to nursing home.

A panel of local professionals was convened which consisted of a general practitioner, an occupational therapist, a social worker, a residential home manager, a community services provider rehabilitation lead and a senior nurse hospital nurse manager.

Panel members signed a confidentiality agreement and were provided with the same information that had been available to the people making the original decision to admit on a permanent basis to a nursing home. Papers that were available at the time of the original decisions were provided and so some were incomplete. Panel members were asked to complete the decision forms independently and without discussion with each other. They were asked to judge, in their professional capacity, whether the person needed to be cared for in a nursing home. In addition, for each case, the panellists were asked to identify:

- Did this person need a facility where a nurse was available at all times?
- Reasons why they did or did not require 24 hour nursing support.
- If this person did not need 24 hour nursing support, what alternative support that is currently available could or should they have had instead?
- If this person did not need 24 hour nursing support, what procedural or other issues or circumstances led to the nursing home placement being made?
- Were there any needs that resulted in the placement being made that could have been provided for in a different way?

Following the panel's audit of the ten cases, the Director of Public Health carried out a rapid assessment of the individual results and facilitated a group discussion about the

cases to identify the reasons for permanent admission to a nursing home, and what factors appeared to have contributed to the original decision. Following the discussion, the panel agreed that three out of the four admissions made to nursing homes made from the community were appropriate (there was no agreement about the fourth case) but that four out of the six admissions made from the hospital had been inappropriate. The findings from this stage fed into the second stage.

Stage 2 – peer review

Following the outcome of Stage 1, the DPH and HASC commissioned an LGA facilitated peer review to critically review and challenge permanent admissions to nursing homes in SG. The peer review would look at the four cases of admission from hospital to nursing home that had been identified as inappropriate.

The review was carried out by an independent panel of peers from the Southwest Region (a Director of Adult Social Care in Wales and a Provider from Gloucestershire) and a separate panel of local partners consisting of the SG CCG, Sirona Health, a social worker and an occupational therapist.

Each participant was provided with all the original paperwork for each of the four cases (although in some cases in a different format), with personal information redacted. The independent panel and SG panel were sent to separate rooms and were asked to read through the case files individually and record their views on how the decisions had been made, focusing on:

- decision-making processes;
- care pathways;
- alternative services/support;
- community/voluntary sector offer;
- professional relationships;
- culture; and
- engagement of individuals and families.

Once they had reviewed the cases individually the panels compared their notes and produced a summary version of the template. The panels were then asked to discuss how things could be done differently; with the peer review panel thinking about this in an ideal world and the SG panel focusing on how things could be done differently in the local context. The two panels then came together for a facilitated “challenge and solutions” session to share their findings and to discuss what could be done differently. The panels were also asked to reflect on the peer review approach as a methodology. These findings were then fed back to a wider group of managers from the health and care sector in SG, who questioned the panels on their findings and recommendations.

Findings

Stage 1 case audit

There was a high level of consensus among the panel members. They disagreed with a majority of the decisions made in hospital (four out of six). Consistent themes emerged from those cases that were identified as inappropriate admissions:

- those assessed as needing permanent nursing home placement tended to be individuals with high needs (poor mobility, falls, skin fragility, incontinence and

multiple medication) and the people performing assessments in hospital appeared to underestimate the ability of community services to support people at home or in a residential facility;

- the documentation often included the phrase “no potential for further improvement or rehabilitation”;
- none of these individuals had night time needs, which suggested that they could be supported by a community services package of support but this did not appear to be considered by the decision makers in hospital; and
- the hospital recommendation for a nursing home placement often reflected a general feeling that a “higher staffing ratio” was needed to look after the individual and it was believed that this could only be provided in a nursing home.

Other themes included the need to discharge the person from hospital, making the decision at too early a point, a lack of consideration of intermediate options such as step down beds and little account taken of the patient’s or family’s wishes.

In addition, the reviewers commented that the paperwork was often poorly filled in with a lack of concordance between the recommendation to admit to a nursing home, the clinical evidence cited on the form and the individual’s or family wishes. Assessments sometimes seemed to be filled in with the conclusion in mind and appeared superficial and contained a lot of narrative about “potential risk”. There was a general sense of risk aversion in the decisions to seek a nursing home placement.

Stage 2 peer review

There was a great deal of consensus between the independent and local panels and their findings were consistent with the stage one case audit.

Decision-making processes. All the decisions were made at a point of crisis and in what appeared to be a tight time constraint. In all cases no other alternatives were considered and the assessments read as though the decision had already been made. Throughout, there was a lack of a person centred approach in the assessments, with a lack of personal outcomes noted. The decisions made appeared risk averse, with the potential of falls and skin integrity often being given as evidence of the need for nursing care. The quality and quantity of the information in order to make the decision was poor with some information missing and at other times incorrect.

Care pathways. In all cases there appeared to be only a single care pathway considered, i.e. admission to a nursing home, with no consideration of whether the outcomes for the individual would be better in a nursing home or elsewhere. Evidence for nursing home admission was medically based and no alternative services were considered, such as a step down offer, community support or re-ablement. There was no consideration of what the voluntary sector could offer in terms of support in any of the cases.

There was also no assessment of the different types of equipment that might enable the patient to stay in their home, for example, mattresses which could reduce the risk of pressure sores. Potential wider issues that might be affecting the individual were not explored, for example, the loss of a spouse or not having their dentures with them.

In all cases the panels felt that there should have been temporary placements made while the individuals’ conditions stabilised. The SG panel suggested that the process of referring to nursing home appeared to be less complex and time consuming than developing a community package and might be seen as a way to achieve a quick

discharge. The independent review panel in particular felt the contrast with how decisions are made with people with learning disabilities was stark, as they would be offered far greater choice and control.

Professional relationships. There appeared to be no shared discussions about any of the cases, with assessments very medically focused.

Culture. The panels suggested that the prevailing culture was one of a risk averse, deficit model, where the individuals were written off, evidence focused on what the individuals were unable to do, with no sense of potential for recovery or what assets individuals might have beyond their current circumstances.

Engagement of users and families. Engagement of the users themselves and their families and friends was scant. Although friends were often named, there was no consideration of how long standing friends/neighbours could be used for support or what social capital the person might have.

Improving the process

A key part of the process was to gain the views of the two panels about what action could be taken to tackle the issues highlighted by their review of the cases.

Embed person centred practice and processes. The panels suggested that there needed to be a better focus on outcomes, choice and control for older people, based on an asset based approach which focuses on what people might be able to do with a bit of support. To support this, assessments should view individuals in the round, as a member of a community, with friends, families and neighbours who might be able to support them, with a little bit of help from services. It was suggested that to support this the paperwork could be re-designed around the National Voices "I statements" (National Voices, 2013).

Take a whole system approach. The peer panels suggested that SG should develop a genuine multi-disciplinary assessment process which includes GPs and providers, including housing providers. The panels were clear about the need for an alternative method for making decisions about permanent admission into care at a point of crisis in a hospital setting.

Develop and communicate alternative pathways to nursing care. Alternative support to nursing care should be understood and taken into account, and where needed, commissioned from housing, voluntary and community sectors. Other support such as assistive technology and telecare, step up and step down offers to prevent unnecessary hospital admissions should be developed and communicated. Both panels suggested that there was good practice already happening in the area and those stories should be gathered and shared in order to show the acute sector that there is a safe alternative to nursing care and engage professionals in multi-disciplinary meetings.

Improve the assessment process. The panels felt that the quality of the assessments should be improved in terms of exploring all the options and particularly in terms of:

- quantity and quality of the data captured and attention to detail;
- knowledge and understanding of the difference between residential and nursing care;
- their understanding of community-based alternatives to residential/nursing care; and
- assessing and planning to achieve individual outcomes.

In addition they suggested that the processes for referring to nursing/residential care and those for developing a community package need to be equal in terms of the effort and time taken so that the process does not steer decisions down a path of “least resistance” to permanent care.

Discussion

SG developed an innovative use of the peer review process in order to help them understand and improve a specific issue, by opening up their case files to local and regional peer review. This section discusses whether the approach delivered on that aim.

The first stage case audit identified four admissions (from six) to nursing home from hospital as inappropriate. That suggested that the local system faces issues that need to be addressed.

The panel discussion at both stages agreed that, on the basis of the evidence in the four case files:

- decisions made in the acute hospital setting were not always in the best long-term interest of the individual;
- the level of influence of professionals based in an acute hospital setting, with a limited knowledge of community-based opportunities, on outcomes was significant;
- the decision-making process is owned by single-organisation (Council) and does not encourage wider system ownership of final decisions and consideration of alternative options;
- the decision-making process is not providing appropriate challenge to decisions made in an acute hospital setting;
- decisions and culture were extremely risk averse, demonstrated a lack of understanding of community assets and services and failed to consider alternative options; and
- individuals and their families were rarely engaged and their wishes were not considered.

The peer review process generated a set of recommendations that SG have begun to implement and which have already started to have a positive impact on practice, including:

- permanent care and nursing home placements are not considered until the person is given the opportunity to re-learn the skills they need for daily living following illness;
- changes to the way community rehabilitation and re-ablement beds are commissioned will help improve the way services work, so that people can receive ongoing support and treatment in their community (including at home) – or through short-term care home beds, as soon as they are ready to leave hospital;
- discharge to assess pilot and service rollout (October 2015) allowing community healthcare teams to provide same-day assessments for people in their own homes on the day of discharge, allowing them to return home as soon as they are no longer in need of hospital care;

- changes in operational practice plus a new pathway demonstrated a positive change to 2014/2015 year end performance data (and corresponding period for 2015/2016); and
- significant changes to the staff and management of the hospital team, impacting on changes to practice.

In addition the process enabled the Council to realise the potential of the contribution the provider sector can make to the assessment process and in improving decision making through a multi-disciplinary approach. The involvement of local partners and regional peer reviewers was successful in terms of identifying the causes of the inappropriate admissions, and recommending ways in which the processes could be improved.

The work is also being developed through the Happy, Healthy and at Home Cluster Integration Project: a joint NHS and Council programme to improve the way that health and adult care services work together, for local people and especially the frail and elderly.

Learning from the process

Methodology

The process was robust and powerful and resulted in some “hard hitting” insights and clear issues for action. The use of an innovative but clear research-based methodology designed and led by the Director of Adult Social Care and the Director of Public Health gave the review a level of credibility and respect amongst Council staff and also other partners. External facilitation was fundamental to the process and overarching methodology. The external facilitator was able to broker the conversations between the external and local panel, help summarise the findings and develop the action plans and provide an external report for the Council and its partners.

The redaction of personal information in the paperwork which was used in Stage 2 was more effective than that used in Stage 1, which involved the signing of a confidentiality statement.

Engagement of local partners

The willingness of partners to participate, particularly providers, suggests that they were invested in and integral to helping to analyse and identify improvements to the processes. The early engagement of colleagues from across different stakeholders, clear articulation of the purpose of the review and the value of individual contributions was important in securing commitment to participate, understanding of the process and useful outcomes.

The findings from Stages 1 to 2 and from both panels in Stage 2 were consistent. This suggests that the process was robust, effective and accessible to all stakeholders irrespective of previous knowledge of the local system. It also suggests that those who made up the local panels were as robust in their analysis of the issues as the independent panel.

The “peer” aspect

The independent panel offered very useful insights into best practice. Given that the peer Director of Social Care was from Wales, it also provided invaluable insights into good practice in a different devolved system. The value of the contribution from the provider sector in both phases was invaluable and brought a different perspective to the peer review. The panel and Council noted that provider input is not something that is routinely considered or valued in current processes.

It was a challenge to secure attendance from regional colleagues to be part of the external peer review panel. It was suggested that this might have been because health colleagues were not aware of the LGA Peer Review Programme and therefore did not recognise its value or significance.

“Being brave”

Those who had participated in the challenge felt that it was both innovative and also a brave approach given that it purposefully exposed the “worst” practice and exposed the Council to robust peer challenge. The peer Director of Adult Social Care from Wales wanted to emphasise how brave it had been for another director to open themselves up to scrutiny over decisions that had been identified as inappropriate. The external panel was particularly keen to stress that these cases had been identified because an inappropriate decision had been made, and were therefore unlikely to be representative of the majority of cases. In addition, the failings identified were those of the whole system, rather than SG Council alone.

Participants found the session interesting and enjoyable, although they were all saddened by the cases they were reviewing, whilst acknowledging that these were examples of poor practice. All those involved in the session thought that the approach was an excellent way of highlighting key issues and developing a way forward.


Conclusion

The combination of case audit and peer review highlighted weaknesses in the assessment processes which were leading to inappropriate admissions from hospital to nursing homes. The use of peer review panels which included providers identified the reasons for the inappropriate admissions and recommended changes to address the issues, which the Council and its partners are now implementing. This suggests that the process is a robust and effective one and other areas could usefully consider commissioning similar approaches via the social care peer review programme.

However, the process was one that opened up the Council to scrutiny of its “worst” cases and as such was regarded by the peer panels as brave. For the process to work, senior managers need to have confidence in the peer reviewers and their own managers and elected members that the findings from the review will be used as learning rather than blame for failure.

The process has had a significant impact across the health and social care system. It has focused decision makers on the importance of making high quality and appropriate decisions that affect an individual’s life at the right time and in the right setting. Further, because the process was delivered with multi-agency participation it has provided a shared diagnostic and learning that has been rapidly taken up by all agencies rather than just one.

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